

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:  
 (a) County \_\_\_\_\_  
 (b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
5331 Walsh St.  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Mo. (b) County \_\_\_\_\_  
 (c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 5331 Walsh St.  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Elizabeth L. Franklin  
 3. (b) If veteran, name war None 3. (c) Social Security No. None

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month July day 16th  
 year 1942 hour 12:25 minute \_\_\_\_\_ P.M. M.

4. Sex Female 5. Color or race White  
 6. (a) Single, widowed, married, divorced, Widowed  
 6. (b) Name of husband or wife Late Sylvester Franklin 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased: June 15th 1888  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from April 27, 1941, to July 16, 1942  
 that I last saw h. pr. alive on July 14, 1942  
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
<input checked="" type="checkbox"/>	<u>54</u>	<u>1</u>	<u>1</u>	hr. _____ min.

Immediate cause of death:  
Myocardial heart disease -  
mitral stenosis &  
auricular fibrillation  
 Duration many years

9. Birthplace Belleville / Illinois  
(City, town, or county) (State or foreign country)  
 10. Usual occupation Housewife

Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
 Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

11. Industry or business \_\_\_\_\_  
 MOTHER FATHER { 12. Name John Morgan  
 13. Birthplace Swansee / Wales  
(City, town, or county) (State or foreign country)  
 14. Maiden name Emma Faustick  
 15. Birthplace Belleville / Illinois  
(City, town, or county) (State or foreign country)

PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. John Liesenfeld  
 (b) Address 5331 Walsh St.  
 17. (a) Burial (b) Date thereof 7-20-42  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Calvary Cemetery

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

18. (a) Signature of funeral director Kriegshauser Mortuaries  
 (b) Address 4228 So. Kingshighway Blvd.  
 19. (a) JUL 17 1942 (b) J. F. Prudek  
(Date received local Registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)  
 (c) Means of injury \_\_\_\_\_  
 23. Signature W. J. Franklin (M. D. or \_\_\_\_\_)  
 Address 634 N. Grand Date signed 7/17/42

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed

*Heinrich A. Lehmann*

Licensed Embalmer No.

*3395*

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**